MONTANA CHEMICAL DEPENDENCY CENTER

PATIENT RECEIPT OF PERSONAL MEDICATION

By my signature, I acknowledge receiving the medications listed below that I personally brought into Montana Chemical Dependency Center at the time of my admission and that were prescribed to me by my personal physician. My signature also relieves Montana Chemical Dependency Center, the Department of Public Health & Human Services and the State of Montana of any liability, now or in the future, for any medical complications that may be associated with my use of these personal, pre-addictions treatment medications.

I have been advised of any potential addictive risks associated with any of these medications and the potential of my use of these medications compromising my addictions treatment and recovery.
Any choice of my use, contrary to this advise, is purely and fully my own responsibility. I have been offered the option of supervised disposal of these medications prior to leaving the facility and I have chosen not to take advantage of this option.

Date Returned	Medication	Dosage	Prescribing Physician

PRINTED PATIENT NAME

PATIENT SIGNATURE_____ DATE

SIGNATURE & TITLE OF STAFF RETURNING MEDICATION:

_____ DATE